Respiratory Update

January 2002

Customer Service is a TOP PRIORITY

The office of the Respiratory Care Board of California places a TOP PRIORITY on customer service. When you call the Board you will be greeted by a live person from the Licensing Program staff. The Executive Officer has received numerous letters where licensees and members of the public have expressed their gratitude for assistance provided by Anna Juarez, Craig Martinez, Rae Woods, and Monica Maldonado above and beyond the call of duty. Whether you are a member of the public or a member of the profession, you can expect to receive prompt and courteous service.

Quality of Care

The health insurance industry has been transformed in recent years with the rise of managed care networks and health maintenance organizations (HMOs). Though these organizations have been praised for bringing affordable health coverage to a wide range of consumers, they have limited treatment options and patient choice.

The quality of care being provided to lung patients is jeopardized when unqualified caregivers are employed in the interest of cutting costs. Both government and non-government payors fail to recognize and allow payment for services provided by respiratory therapists to patients with lung diseases. As a result, health care providers are directing low-wage, untrained personnel to deliver care to this growing population of patients with complex conditions currently representing the fourth leading cause of mortality in the United States.

This problem appears to be predominant in skilled nursing facilities, with home medical device retailer facilities, out-patient office pulmonary spirometry and at sleep centers where polysomnography is performed. Lung patients have complex medical conditions. Treating them requires the skills and knowledge of highly trained, licensed respiratory therapists.

Ironically, there is now a body of research showing costs are better controlled and quality of care improved when the care of patients with lung diseases, as ordered by a physician, is delivered by a licensed respiratory therapist. In recognition of this, many of the national physician associations have issued resolutions stating their support for respiratory therapists.

At its August 10th meeting, the Board developed a task force to research care being provided by unlicensed and/or licensed but untrained care-givers to lung patients. President Barry Winn, Ed.D. RCP and member Richard L. Sheldon, M.D. are working together with members of the respiratory care profession to gather information on this subject. If you have any information that may help the Board in its fact-finding mission, please send your written comments to the Sacramento Board office or by way of e-mail to: rcbinfo@dca.ca.gov . Please direct all correspondence to Stephanie Nunez, Executive Officer.

Inside This Issue

Barry Winn, Ed.D, RCP
Board President

A Message from the President...

First, I want to thank all those students, program directors, and members of the public for attending the Respiratory Care Board of California's (Board) November 9th meeting in Burbank. The atmosphere at the meeting was encouraging and signaled a new era for the respiratory care profession and the Board. The Board is eager to revisit its Strategic Plan in February and chart a new and exciting course.

The Board was established in 1982, and California was the first state to require licensure for respiratory care practitioners. Today, there are 42 states that require licensure plus two states that require registration. The Board was established because the Legislature found that the "practice of respiratory care in California affects the public health, safety and welfare and is to be subject to regulation and control in the public interest to protect the public from the unauthorized and unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care." To sum it up in four words, the mandate of the Board is "to protect the public."

One way the Board can do this is by showing its support for legislation that will ensure the public has access to respiratory care practitioners. At its November 9th meeting, the Board approved a letter of support for respiratory therapists to gain recognition under the Medicare home health services benefit.

In addition, the Board lowered the initial license and transcript review fees effective January 1, 2002, so that fees to gain licensure would not hinder students from entering the field. We hope that these efforts in conjunction with the many efforts made by professional associations and program directors will eventually make a positive impact on the shortage of therapists in our State.

The Board is moving forward to establish Ethical Guidelines for therapists to help convey what it means to be a professional. One way leaders in this profession can help is by supporting these guidelines and educating their colleagues about their responsibility as licensed practitioners and the need to act responsibly at work and in their community. It is one of the ways we can decrease costs and ultimately reduce licensure fees.

The other way is for the Board to continue evaluating the disciplinary process and making changes that make sense from both a professional and public protection perspective. I believe that process is already making headway. The Board is moving forward with revisions to its enforcement process that are expected to reduce expenditures significantly while maintaining public protection.

The Board sincerely wants to hear what consumers, employers and respiratory care practitioners have to say. Do you have any suggestions or ideas that would better protect the public? What is happening at your work site? Are there areas where consumers may be at risk that need to be examined more closely? Are there laws preventing the public from having access to therapists? Do you believe there is a process that can be changed to save time and/or money? If you have any suggestions or comments, please send Stephanie Nunez, Executive Officer an e-mail at: rcbinfo@dca.ca.gov. We look forward to hearing from you.

About the Board

The Respiratory Care Board of California (Board) is pleased to announce several recent appointments to the Board. The Board is comprised of nine members with three members appointed by each, the Governor, the Senate Rules Committee, and the Speaker of the Assembly. There are four public members, four respiratory care practitioner members and one physician and surgeon member. Current members of the Board include:

Barry Winn, Ed.D., RCP, President
Larry L. Renner, RCP, Vice-President
Gopal D. Chaturvedi (Public Member)
Eugene Mitchell (Public Member)
Richard L. Sheldon, M.D.
Barbara Stenson, RCP
Gary N. Stern, Esq. (Public Member)
Scott J. Svonkin (Public Member)

At the Board's November 9th meeting, it was announced that Stephanie Nunez was appointed to serve as the Board's new Executive Officer.

Pocket Licenses

This fall, the colors of the Respiratory Care Board of California's (Board) pocket respiratory care practitioner (RCP) license were changed. The next time you renew your license you will receive a grey pocket license with blue writing (previously green with black writing). The change was made at the time the Board moved its Sacramento office to accommodate the numerous concerns employers had with the inability to copy the pocket license for employment files and records. The new colors accommodate this concern.

However, employers and licensees should be aware that the actual pocket license should be produced to verify licensure. Pursuant to Business and Professions Code, Section 3750.6, every holder of a pocket license shall have readily available for immediate inspection the original pocket license issued by the Board.

For absolute verification, an employer or person requesting the status of an RCP license should contact the Board at (916) 323-9983 or look up the status on the Board's Web site, www.rcb.ca.gov, which is updated daily.

Continuing Education Provider Approval

The Respiratory Care Board of California (Board) is working on proposed language that would implement a Continuing Education (CE) Provider Approval Program. The Board's goal is to establish language that works for everyone, with the primary objective being language that will ensure only quality CE is provided for respiratory therapists. The Board currently has regulations that define approved CE courses but do not call for the review or approval of CE providers.

The Board is developing a plan to gain input from the profession before language is finalized. The plan will include gathering input from the profession and existing CE providers, researching other existing CE approval programs, preparing proposed language, taking additional suggestions or comments, and most likely revising the proposed language for submission to the Office of the Administrative Law to begin the rulemaking process (to establish regulatory language). It is expected that this process will take nearly a year to complete.

Be sure to check our Web site at www.rcb.ca.gov for up to date information. You are encouraged to get involved in the process and make comments in support or opposition to the proposed language. These regulations will affect each licensee in that the required continuing education for renewal must be taken through Board approved providers.

Board Meeting

The next Respiratory Care Board of California meeting will be held in Sacramento, California and is tentatively scheduled for Thursday, February 21 and Friday, February 22, 2002. The Board's annual strategic planning session will also take place at this meeting.

Please visit our Web site at www.rcb.ca.gov for more information on meeting dates, times and locations. Agendas for upcoming meetings are available 10 days prior to meeting dates.

Fee Changes

At the Respiratory Care Board of California's (Board) August meeting, numerous fees were changed to coincide with fees charged by other allied-health boards. All fee changes went into effect January 1, 2002.

The duplicate license fee was reduced from $75 to $25. Respiratory Care Practitioners (RCP) are required by law to produce their original pocket license issued by the Board upon request by any person. RCPs who lose their license will be charged $25 to replace the license. Further, for RCPs who provide evidence, such as a police report, that their license was stolen, the duplicate license fee will be waived.

The endorsement fee was reduced from $100 to $75. RCPs who need an official certification of licensure, most commonly used when a California RCP is attempting to gain licensure in another state, will be charged $75.

The transcript review fee was reduced from $100 to $75. This fee is charged to all applicants for licensure. The Board is taking a closer look at this process to see if the fee may be further reduced or eliminated entirely.

The initial license fee was reduced from a $200 flat fee to $8 per each month the initial license is issued. Previously, the initial license fee was a flat rate of $200 and the initial license was issued anywhere from 12 - 23 months (dependent upon each applicant's birth month). Effective January 1, 2002, initial licenses are issued for a period of 6 to 17 months (again depending on the applicant's birth month) and the fee is now $8 for each month the license is issued. The initial license fee now ranges from $48 to $136 depending upon the number of months the license is issued.

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The renewal fee was increased from $200 to $230. RCPs with an expiration date on or after January 1, 2002, will be charged $230 to renew their license. This fee increase was necessary in order for the Board to maintain a solvent fund. The fee was initially planned to be implemented January 1, 1999, however the Board was successful in postponing the implementation for three years. The Board is working hard to find other avenues to reduce this fee in the future or at a minimum, prevent the fee from increasing for many years.

Why Are We Charged More than Other Allied Health Care Professionals?

This is a very common question that most respiratory care practitioners (RCP) have probably pondered at one time or another. Most often RCP fees are compared to fees for Licensed Vocational Nurses and Registered Nurses. Following is a comparison of the number of licensees, fees, and revenues generated from several health boards:

License Type	No. Active Licensees/ Registrations	Biennial Renewal Fee	Revenue Generated (every 2 yrs)
Podiatry	1,956	$900	$1,760,400
Physician & Surgeons	108,068	$600	$64,840,800
Psychology	14,386	$400	$5,754,400
Acupuncture	5,253	$325	$1,707,225
Optometry	6,166	$300	$1,849,800
Physician Assistants	14,398	$300	$4,319,400
Psychiatric Tech	9,730	$240	$2,335,200
RCP	**13,572**	**$230**	**$3,121,560**
Physical Therapist	20,642	$120	$2,477,040
Pharmacy	52,673	$115	$6,057,395
LVN	65,542	$100	$6,554,200
RN	250,207	$80	$20,016,560

Figures obtained from 99/00 Annual Reports and Web sites. The fee for Physician Assistants is effective 7/02.

Although there are numerous variables that affect the biennial license fee for each board, a large factor is attributed to the number of active licensees. Generally, the fewer number of licensees, the greater the fee and the greater number of licensees the lower the fee. You will note from the above chart that the renewal fee for RCPs, based on the number of active licensees, is in line with other boards. In fact, there are a few boards with a greater number of active licensees that have a higher renewal fee.

Even so, the members of the Respiratory Care Board of California (Board) are working to prevent fees from increasing. You can help by contributing any way you can in promoting your profession and upholding the ethical guidelines that will be adopted by the Board.

Sunset Review

The Joint Legislative Sunset Review Committee (Joint Committee) is responsible for determining whether the State should continue to regulate many areas and professions under the umbrella of the Department of Consumer Affairs, such as the regulation of respiratory care practitioners. It is also responsible for determining if changes should be made to improve the overall effectiveness and efficiency of these boards and programs, to ensure the interests of California's consumers are protected against incompetent practice or illegal activities of these professionals.

The Respiratory Care Board of California (Board) submitted its 2001 Sunset Review Report to the Joint Committee on September 1, 2001. A copy of the entire report can be viewed on and/or printed from the Board's Web site at www.rcb.ca.gov.

The Joint Committee held a hearing on December 5, 2001, to review the Board, along with several other boards. Over the next few months the Department of Consumer Affairs will offer recommendations for consideration by the Joint Committee. The Joint Committee will then meet the first week in April to vote on final recommendations for each board and program. You can find more information regarding the Sunset Review process and the Board's review online at: www.sen.ca.gov/jlsrc.

Scope of Practice Inquiries

Over the years, the Respiratory Care Board of California (Board) has received hundreds of inquiries regarding the respiratory care practitioner scope of practice. The Board anticipates having many of these inquiries and responses posted on its Web site in the early part of 2002. Here are a few of the most recent inquiries:

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Inquiry: I work for a medical group that is run by physicians and they have a respiratory department with respiratory therapists. They wanted to know if we could hire a technician that would be trained by the RT to drop off nocturnals to some of the patients the RT couldn't get to right away. They wanted to know if that would be legal or illegal.

***Response*:** There is nothing in the Respiratory Care Practice Act (Practice Act) to preclude this activity as long as it is done under the direction of a licensed physician. In addition, protocols should be in place directing how this function should be performed, as well as documentation of the training and competence of the technicians performing the service.

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***Inquiry*:** How does the board stand on floating and practicing in areas of the hospital in which the RCP has not been trained? Myself and other RCPs who have only worked in the neonatal specialty area for 20 years or greater, are now being sent to the adult areas of the hospital without training.

***Response**:* Nothing in the Practice Act precludes this. Licensure as a RCP implies competency in all areas of respiratory care and does not set limits on where the qualified RCP practices. It is recommended that your personal continuing education activity be directed towards upgrading your skills in adult respiratory care.

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Inquiry: Licensed respiratory therapists are allowed to suction, change trach dressings, set-up and deliver prescribed oxygen therapy as are licensed registered nurses and licensed vocational nurses. Can any other non-licensed caregivers perform the above-noted procedures in an acute or subacute facility? If so, would you please provide me with a list of these positions and any relevant training information?

Response: The above-mentioned procedures constitute the practice of respiratory care; therefore, these procedures must be implemented only by personnel who are appropriately licensed to provide these services. Further, the Practice Act authorizes the practice of respiratory care by licensed RCPs and other licensed health-care personnel whose overlapping scope of practice includes the practice of respiratory care or components thereof. The practice of respiratory care, in California, by unlicensed persons is prohibited.

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Inquiry: I have a question concerning any legal regulations, (Title 22 or other), that pertain to or require acute-care facilities in the state of California to have Respiratory Care Managers that are Respiratory Therapists to oversee Respiratory Care Departments. There is growing concern that Administration at this facility as a cost-cutting measure would like to consider elimination of the management positions in some of the ancillary service departments and lump them under nursing. Any information on this issue would be appreciated.

Response: In response to your inquiry regarding any legal regulations, (Title 22 or other), that pertain to or require acute-care facilities in the State of California to have Respiratory Care Managers that are Respiratory Therapists to oversee Respiratory Care Departments, please be advised that the Respiratory Care Practice Act (RCPA) does not regulate administrative issues relative to who oversees hospital departments. Inquiries related to the interpretation of Title 22 should be forwarded to the Department of Health Services. Their address and telephone number is: Department of Health Services, PO Box 94273, Sacramento CA 95814, (916) 445-4171.

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Inquiry: Thank you for sending a response to the institution I work for on the subject of RCPs hanging I.V.'s and preparing non-respiratory medications such as Dopamine and epinephrine. The Pharmacy department and Nursing department continue to request more clarification to this subject and whether a Respiratory Care Practitioner can (under California Scope of Practice) mix and set-up for I.V. delivery, non-respiratory medications such as Dopamine and epinephrine. When you sent me copies of the board's response to previous letters, I interpreted the response to

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define my question as a class #2 task which is within an RCP's scope, but training is recommended as defined by the individual situations. I would appreciate clarification to this question in order to resolve Pharmacy and Nursing's continued need for a clear definition.

Response: In response to your inquiry, you have interpreted the Respiratory Care Board's response correctly. One other caveat should be added: all respiratory care practice activity should be under direction of the Medical Director or Medical Director approved protocols. Training is again emphasized.

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Inquiry: Over the past year our hospital has been having problems in hiring enough staff to cover shifts (12-hours shifts). All of the current staff has been covering the shifts that were not covered. Due to low wages and high work loads, new hires quit or decide not to work at this facility. The question we have is the hospital's administration has threatened us with the loss of our license on the grounds of patient abandonment to force us to stay and work overtime shifts because they cannot find coverage for that particular shift? The union (Local 228 Teamsters) says that state law forbids forced overtime, in a non-disaster situation. The hospital is aware of our staffing needs and refuses to address it and expects our staff to continue to pick up the non-scheduled shifts with threats. We need to know our rights and course of action from the Respiratory Care Board.

Response: In response to your inquiry regarding RCPs being required to do overtime, please be advised that the RCB does not have the authority to sanction the hiring or firing of hospital employees. Each organized health-care system is responsible for establishing these guidelines within their respective systems.

In addition, Section 3758 of the Business & Professions Code states:

"Any employer of a respiratory care practitioner shall report to the Respiratory Care Board the suspension or termination for cause of any practitioner in their employ. The reporting required herein shall not act as a waiver of confidentiality of medical records. The information reported or disclosed shall be kept confidential except as provided in subdivision (c) of Section 800, and shall not be subject to discovery in civil cases."

Further, employers are subject to an administrative fine of up to $10,000 for failure to make a report as required.

Upon notification of suspension or termination, the RCB investigates the cause and determines what action, if any, will be taken against the RCP's license. The RCB retains the sole decision regarding who will or will not lose their license to practice respiratory care in the State of California. The RCB advises you to obtain competent legal counsel in order to evaluate these provisions and how they relate to the issue described above.

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***Inquiry*:** I am writing on behalf of the Critical Care Department at a children's hospital. We have been struggling for the last year with the issue of RCPs having access to medications other than strictly "respiratory medications." It's been the practice in our unit for many years to assist the nursing staff during times of high acuity and patient census by delivering medications (with the exception of narcotics) to the nurse at the bedside. There are several people within our institution who have expressed concerns that this practice is illegal. (1) Will you please comment on whether this is within the RCP's scope of practice? (2) What is the Board's position on IV insertion, medication administration by specialty trained protocol driven transport teams, and RCPs verifying drug doses and narcotic waste with a RN?

Response: In response to your inquiry received regarding RCPs assisting the nursing staff by delivering any medication to the nurse at the bedside, please be advised that there is no prohibition for this activity in the Respiratory Care Practice Act (RCPA) or its regulations; that is, the RCPA is mute on this matter.

In response to your inquiry regarding IV insertion, medication administration by specialty trained protocol driven transport teams, and RCPs verifying drug doses and narcotic waste with an RN, please be advised that this is nearly verbatim from the RCPA and allowed.

Board Member Recognition

The Respiratory Care Board of California (Board) is pleased to announce that its physician and surgeon member, Richard L. Sheldon, M.D. was selected for the American Association for Respiratory Care's (AARC) Jimmy A. Young Medal, which was presented to him at the AARC's International Respiratory Congress Convention this December. The AARC states that the Medal "is presented each year to an individual who has gone above and beyond the call of duty in supporting the Association and the respiratory therapists it represents."

"Over more than 30 years of association with the AARC, Dr. Sheldon has devoted countless hours of his personal time to present lectures, attend meetings, offer counsel, advocate with outside groups, and deliver unparalleled wisdom aimed at enhancing the profession and its practitioners." You can find AARC's complete article titled, "AARC Awards 2001 Jimmy A. Young Medal to Richard Sheldon, MD" in the September 2001 issue of the *AARC Times*.

Congratulations Dr. Sheldon for recognition of your hard work!

Richard L. Sheldon M.D.
Board Member

DID YOU HEAR?

So many times, respiratory care practitioners voice great ideas or valid concerns that do not make it to the right ears. Your opinion matters. If you have issues or concerns or ideas you think would better serve the consumers of California or the respiratory care profession, we want to hear from you. You can either write us a letter or send us a quick e-mail (rcbinfo@dca.ca.gov). The Executive Officer will review suggestions on a routine basis to identify those issues within the purview of the Board. Please be an active participant in licensing your profession.

Ethical Guidelines

At its November 2001 meeting, the Board reviewed and is moving forward with adopting its own Ethical Guidelines. These guidelines were developed to give respiratory care practitioners rules to follow that will ensure successful licensure and, in the long run, promote the respiratory care profession.

The largest portion of your fees, without a doubt, is directed to operating the Board's Enforcement Program. Though only a small percentage of licensees and applicants enter the Board's Enforcement Program, each enforcement case incurs anywhere from $200 to $5,000 in costs, not including Board staff wages. The Board is striving to educate and inform respiratory care practitioners of their responsibilities as professionals, to prevent incidents that will result in enforcement action. One way leaders in this profession can help is by supporting these guidelines and educating their colleagues about their responsibility as licensed practitioners and the need to act responsibly at work and in their community. It is one of the ways we can decrease costs and ultimately reduce licensure fees.

In addition, the Board's physician member, Dr. Richard Sheldon, is chairing a committee for the American Association for Respiratory Care to establish its ethical guidelines, which are expected to be made public in the latter part of 2002. The Board is planning on reviewing these guidelines once they are established to see if additional modifications to its guidelines would be beneficial.

On page 8, you will find a draft of the Ethical Guidelines currently under consideration by the Board.

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RESPIRATORY CARE BOARD OF CALIFORNIA
ETHICAL GUIDELINES

DRAFT

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a California licensee and a member of this profession, a respiratory care practitioner must recognize responsibility to patients first and foremost, as well as to society, to other health professionals and to self. Respiratory care practitioners have a wide variety of skills, education, experiences, abilities, needs, values, expectations and aspirations. Respiratory Care Practitioners are health care professionals and should at all times conduct themselves as professionals.

The following principles are not necessarily laws, but standards of conduct that define the essentials of appropriate behavior for a licensed respiratory care practitioner in California. The consumers of California expect respiratory care practitioners to:

Respect and adhere to "Respiratory Care Patients' Rights."

Demonstrate behavior that reflects integrity, supports objectivity, and fosters trust in the profession and its professionals.

Perform only those procedures or functions in which they are individually competent and which are within the scope of accepted and responsible practice.

Function as leaders in specialized areas of expertise.

Respect and protect the legal and personal rights of patients they care for, including, but not limited to, the right to informed consent and refusal of treatment.

Divulge no confidential information regarding any patient or family unless disclosure is required for responsible performance of duty, or required by law.

Place the needs of the patient first.

Provide care without discrimination on any basis, with respect for the rights and dignity of all individuals.

Maintain a positive attitude and demonstrate proper etiquette for each situation.

Actively maintain and continually improve professional competence, and represent it accurately. Commit to the continuing education required for licensure and to maintain skills with advancements made in the respiratory care field.

Promote disease prevention and wellness.

Promote health care delivery through improvement of the access, efficacy, and cost of patient care.

Follow sound scientific procedures in research.

Comply with state or federal laws that govern and relate to the practice.

Refuse to participate in illegal or unethical acts, and refuse to conceal illegal, unethical or incompetent acts of others.

Avoid any form of conduct that creates a conflict of interest, and follow the principles of ethical business behavior.

As health care professionals engaged in the performance of cardiopulmonary care, respiratory care practitioners must strive to maintain the highest personal and professional standards. In addition to upholding the code of ethics, the respiratory care practitioner shall serve as a leader and advocate of public health.

Accountability is the price paid for this privilege and society expects professions to self-regulate and police their individual and group behavior through various mechanisms, including through California licensure with the Respiratory Care Board. Employers as well as respiratory care practitioners are mandated by law, to report violations of laws and regulations governing the practice of respiratory care.

RCPS Under the Medicare Home Health Services Benefit

The Respiratory Care Board of California (Board) is mandated to protect the public from the unauthorized and unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care. The Board believes that, in addition to carrying out its legal mandate, it can also serve the public by supporting or opposing legislation that affects consumer access to services provided by respiratory care practitioners (RCP).

The American Association for Respiratory Care (AARC) has headed up a campaign to gain recognition of respiratory therapists under the Medicare home health services benefit. As stated by the AARC, currently, respiratory patients have limited access to respiratory therapy and therapists in the home-health setting. With the rapidly climbing rate of chronic obstructive pulmonary disease (COPD) in the U.S. and other types of lung disease, access to home health care is becoming more and more important. The Board is supporting this campaign and has taken the position that failure to recognize respiratory therapists under this benefit jeopardizes patient safety and prevents consumers from receiving the best care for their respiratory illnesses.

At its November, 2001 meeting, the Board moved to send the letter shown on page 10, to Legislators requesting recognition of therapists under this benefit.

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MANDATORY REPORTING

Respiratory care practitioners (RCP) and their employers are required by law to report violations of the Respiratory Care Practice Act and the regulations governing the practice of respiratory care to the Respiratory Care Board of California (Board). RCPs are required by law to report to the Board any person that may be in violation of, or has violated, any of the laws and regulations administered by the Board. Employers are required by law to report to the Board the suspension or termination of any RCP in their employment, for any one or more of the following causes:

- **Use of controlled substances or alcohol that impairs a RCP's ability to safely practice**
- **The unlawful sale of controlled substance(s) or prescription item(s)**
- **Patient neglect, physical harm to a patient, or sexual contact with a patient**
- **Falsification of medical records**
- **Gross incompetence or negligence**
- **Theft from patients, other employees, or the employer.**

RCPs are subject to discipline and will be subject to a fine of up to $2,500 and employers are subject to a fine of up to $10,000 for failure to make a report as required.

Education Requirements

The Respiratory Care Board of California (Board) will be discussing at its February meeting, the need for legislative and regulatory amendments to its education requirements. Valid concerns were raised by Senator Figueroa (D-Fremont), Chair of the Joint Legislative Sunset Review Committee and her Chief Staff Counsel, Edward Howard, regarding the Board's authority and lack thereof for the Board's education requirements.

Discussion at the next Board meeting is expected to include:

- the need to clarify the requirement for an Associate Degree
- the need for language that would allow exemptions, such as experience or licensure in another state, in lieu of some education requirements
- the possible need for additional clinical experience for foreign applicants
- the need to approve schools or determine if accreditation agencies are performing quality reviews to the satisfaction of the Board
- the possibility of phasing-out the transcript review process

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November 16, 2001

The Honorable Pete Stark
239 Cannon House Office Building
U.S. House of Representatives
Washington, D.C. 20515

RE: ACCESS TO RESPIRATORY THERAPISTS IN THE HOME

Dear Congressman Stark:

The Respiratory Care Board of California (Board) is the State agency created by the Legislature charged with protecting the public from the unauthorized and unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care. The Board strongly supports and urges that respiratory therapists are recognized under the Medicare home health services benefit with the following suggested language:

> "A respiratory therapist may be utilized as a substitute when respiratory therapy services are furnished as part of a plan of care by a licensed nurse or physical therapist under the Medicare home health services benefit (Section 1861(m) of the Social Security Act)."

Currently, home respiratory therapy is covered under Medicare when it is part of a plan of care by a nurse or a physical therapist. The proposed language would recognize respiratory therapists and allow their services to be considered a skilled visit under the plan of care. Respiratory therapists are formally educated, clinically trained, and competency tested in their field. For Medicare beneficiaries who are ventilator dependent, or who suffer from Chronic Obstructive Pulmonary Diseases such as emphysema and chronic bronchitis, respiratory therapists may be the best provider option. By not recognizing respiratory therapists under the Medicare home health services benefit, patient safety may be jeopardized and consumers are prevented from receiving the best care for their respiratory illnesses.

There is now a body of research which shows that costs are better controlled and quality of care improved when the care of patients with lung diseases, as ordered by a physician, is delivered by a licensed respiratory therapist. In recognition of this, many of the national physician associations have issued resolutions stating their support for respiratory therapists (see enclosures).

As you know, no additional expenses would incur from this requested change. Rather, it would provide for a different, and in some cases, more qualified therapist. Further, this recognition would not mandate the use of respiratory therapists, but rather, provide the opportunity for patients with respiratory diseases to obtain the best possible treatment.

Thank you for your consideration in this matter. Should you have any questions, please do not hesitate to contact our Executive Officer, Stephanie Nunez at (916) 323-9983.

Sincerely,

Barry Winn, Ed.D. RCP
President

Enclosures

Mission Statement

The mission of the Respiratory Care Board of California is to protect and serve the consumer by administering and enforcing the Respiratory Care Practice Act and its regulations in the interest of the safe practice of respiratory care.

Home Medical Devices

Effective July 1, 2001, the medical device retailers program previously regulated by the Board of Pharmacy was transferred to the Department of Health Services (DHS). In addition, the name of the expanded license category was revised to Home Medical Device Retail Facilities (HMDRFs).

The Health and Safety Code, sections 109948 and 109948.1 define HMDRF and home medical device and services as follows:

"(a) 'Home medical device retail facility' is an area, place, or premises, other than a licensed pharmacy, in and from which prescription devices, home medical devices, or home medical device services are sold, fitted, or dispensed pursuant to prescription. 'Home medical device retail facility' includes, but is not limited to, any area or place in which prescription devices, home medical devices, or home medical device services are stored, possessed, prepared, manufactured, or repackaged, and from which the prescription devices, home medical devices, and home medical device services are furnished, sold, or dispensed at retail…."

"(a) 'Home medical device services' means the delivery, installation, maintenance, replacement of, or instruction in the use of, home medical devices used by a sick or disabled individual to allow the individual to be maintained in a residence.

(b) 'Home medical device' means a device intended for use in a home care setting including, but not limited to, all of the following:

(1) Oxygen delivery systems and prefilled cylinders.
(2) Ventilators.
(3) Continuous Positive Airway Pressure devices (CPAP).
(4) Respiratory disease management devices.
(5) Hospital beds and commodes.
(6) Electronic and computer driven wheelchairs and seating systems.
(7) Apnea monitors.
(8) Low air loss continuous pressure management devices.
(9) Transcutaneous Electrical Nerve Stimulator (TENS) units.
(10) Prescription devices.
(11) Disposable medical supplies including, but not limited to, incontinence supplies as defined in Section 14125.1 of the Welfare and Institutions Code.
(12) In vitro diagnostic tests.
(13) Any other similar device as defined in regulations adopted by the department.

(c) The term 'home medical device' does not include any of the following:

(1) Devices used or dispensed in the normal course of treating patients by hospitals and nursing facilities, other than devices delivered or dispensed by a separate unit or subsidiary corporation of a hospital or nursing facility or agency that is in the business of delivering home medical devices to an individual's residence.

(2) Prosthetics and orthotics.
(3) Automated external defibrillators (AEDs).
(4) Devices provided through a physician's office incident to a physician's service.
(5) Devices provided by a licensed pharmacist that are used to administer drugs that can be dispensed only by a licensed pharmacist.
(6) Enteral and parenteral devices provided by a licensed pharmacist."

Often the Respiratory Care Board of California (Board) is asked whether or not the delivery, set-up and instruction of home medical devices constitute the practice of respiratory care. The delivery of home medical devices may be performed by an unlicensed person**. However, the delivery of equipment does NOT include application of the equipment to a patient or instruction in the use of the equipment for the purpose of deriving the intended medical benefit. Such services are the practice of respiratory care.**

…continued on page 12

"…the delivery of equipment does NOT include application of the equipment to a patient or instruction in the use of the equipment for the purpose of deriving the intended medical benefit. Such services are the practice of respiratory care…"

Therefore, set-up or application of these devices to a patient or instruction in the use of the equipment for the purpose of deriving the intended medical benefit must be performed by a licensed respiratory care practitioner or other qualified licensed persons authorized by their respective licensing statute to practice respiratory care. Unlicensed persons are prohibited from practicing respiratory care in the State of California.

There is growing concern that Home Medical Device Retail Facilities may be employing "drivers" to perform services beyond the delivery of home medical devices. The Department of Health Services states that complaints of unlicensed or unqualified persons performing services beyond the delivery of home medical devices should be reported immediately to the Department of Health Services. The DHS considers this type of practice a public health issue and will take immediate action. However, the DHS will not take action for complaints related to "scope of practice." The DHS has investigators that are sworn peace officers that can access patient charts, facility records, etc…. The DHS has the authority to obtain all information needed and, if allegations are substantiated, they can take immediate action against the facility. The DHS stated that complaints and if available, investigative material, pertaining to a person who has unlawfully practiced respiratory care would be forwarded to the Respiratory Care Board to file a complaint with the appropriate district attorney.

Contact information
Department of Health Services
Food & Drug Branch
P O Box 942733
Sacramento CA 94234-7320
(916) 445-2263
DHS Consumer Complaint Line: 1-800-495-3232

Web Site Features

The Respiratory Care Board of California's (Board) Web site has proven to be a valuable tool for communication. If you haven't already done so, please visit us at www.rcb.ca.gov. The site is updated continuously and in some cases it is the first location announcements are made available. Some of the information you will find at the site includes:

- Board member information and meeting dates, agendas and minutes
- Applicant information including the entire application for licensure
- License verification by fax and the newest component to VERIFY LICENSURE ON-LINE!
- Enforcement information including how and when to file a complaint and the *Respiratory Stat* which lists the latest disciplinary action taken by the Board.

And coming soon. … scope of practice inquiries and responses from the Board. The Board will be posting several of the most common scope of practice inquiries made to the Board in recent years.

FDA Public Health Advisory – Medical Gas Mix-Ups

The Food and Drug Administration published a Public Health Advisory in March 2001 to alert health-care facilities to the hazards of medical gas mix-ups and made several recommendations that only qualified and trained personnel handle these gases. Licensed Respiratory Care Practitioners (RCP) are the most qualified professionals to handle these gases since RCPs are educated and trained in the safety and handling of medical gas systems.

In the State of California, the set-up or application of medical gas systems to a patient or instruction in the use of the equipment for the purpose of deriving the intended medical benefit constitutes the practice of respiratory care. These services must be performed by a licensed respiratory care practitioner or other qualified licensed persons authorized by their respective licensing statute to practice respiratory care. Unlicensed persons are PROHIBITED FROM PRACTICING RESPIRATORY CARE in the State of California. The unauthorized practice of respiratory care can result in criminal prosecution.

The full advisory can be found online at www.fda.gov/cder/guidance/4341fnl.htm and reads as follows:

…continued on page 13

...FDA Advisory continued from page 12

Guidance for Hospitals, Nursing Homes, and Other Health Care Facilities
FDA Public Health Advisory[1]

This guidance represents the Food and Drug Administration's (FDA's) current thinking on this topic. It does not create or confer any rights for or on any person and does not operate to bind FDA or the public. An alternative approach may be used if such approach satisfies the requirements of the applicable statutes and regulations.

I. INTRODUCTION

This guidance is intended to alert hospitals, nursing homes, and other health care facilities to the hazards of medical gas mix-ups. The Food and Drug Administration (FDA) has received reports during the past 4 years from hospitals and nursing homes involving 7 deaths and 15 injuries to patients who were thought to be receiving medical grade oxygen, but were receiving a different gas (e.g., nitrogen) that had been mistakenly connected to the oxygen supply system. This guidance makes recommendations that will help hospitals, nursing homes, and other health care facilities avoid the tragedies that result from medical gas mix-ups.

II. BACKGROUND

On December 7, 2000, a nursing home in Bellbrook, Ohio, reported 2 patient deaths and 8 patients injured following a mix-up in their oxygen supply system. The nursing home had supposedly received a shipment of four cryogenic vessels[2] containing medical grade oxygen. Included in the delivery, however, was a cryogenic vessel of industrial grade nitrogen. The nursing home was running low on oxygen and sent a maintenance employee to connect a new oxygen vessel to the oxygen supply system. The employee selected the nitrogen vessel and discovered, correctly, that he was unable to connect the vessel to the oxygen system - as a safeguard, the connectors for oxygen vessels are specially fitted so they are compatible only with oxygen delivery systems. The employee removed a fitting from an empty oxygen vessel and installed it on the nitrogen vessel. He then connected the deadly product to the oxygen system. Several days later, 2 of the injured patients died from exposure to industrial nitrogen, bringing the death total from this one incident to 4.

On April 22, 1998, a hospital in Idaho discovered that a large cryogenic vessel of industrial nitrogen had been connected to the oxygen system supplying the operating rooms, labor and delivery rooms, and emergency room. The hospital discovered that the medical gas delivery person initially had been unable to connect the incompatible nitrogen vessel outlet fitting to the oxygen system, but had used a wrench to disconnect the nitrogen fitting and replace it with an oxygen fitting. Two patients died as a result of this medical gas mix-up.

In October 1997, a hospital in Nebraska received a shipment of medical grade oxygen in large cryogenic vessels. The shipment included one cryogenic vessel of industrial grade argon that was properly labeled. The hospital was running low on oxygen and sent a maintenance employee to connect an oxygen vessel to the oxygen supply system. Without examining the label, the employee selected the argon vessel, and, discovering he was unable to connect the vessel to the oxygen supply system, he removed a fitting from an empty oxygen vessel, installed it on the argon vessel, and connected the deadly product to the oxygen system. Argon was administered to a patient undergoing minor surgery. The patient died.

On December 2, 1996, a childrens' home located in New York reported adverse reactions experienced by nine patients due to the inhalation of carbon dioxide. An employee of the home, asked to attach a large cryogenic vessel of medical grade oxygen, unknowingly selected a carbon dioxide vessel from the home's inventory. He noted that the fitting on the carbon dioxide vessel was not compatible with the connector on the oxygen system. Nonetheless, he removed an oxygen fitting from an empty vessel, installed it on the carbon dioxide vessel, and attached it to the oxygen supply system. Two patients were injured critically, and four patients experienced varying stages of respiratory distress.

All four cases reveal striking similarities:

The person connecting the vessel to the oxygen system (e.g., the delivery person or the facility employee) was not properly trained and did not understand that connection incompatibility is a built in safeguard.

Prior to installing the cryogenic vessel to the oxygen supply system, the person making the connection did not examine the drug label applied to the cryogenic vessel to ensure that the product was medical oxygen.

...continued on page 14

...FDA Advisory continued from page 13

The Agency has identified additional practices that may contribute to continuing medical gas mix-ups resulting in injury and death:

Although recommended by the Compressed Gas Association, many of the large cryogenic vessels used to contain medical gases do not have permanently brazed, or welded, connections or fittings that cannot be removed.

Unfortunately, not all medical gas vessels are labeled using 360-degree wrap-around labels.

Separate storage areas often are not provided either in the delivering vehicle or at the receiving facility to sufficiently separate medical grade products from industrial grade products.

As a result, many medical gases are improperly or poorly labeled; the wrong gases are delivered accidentally to hospitals, nursing homes, and other health care facilities; and poorly trained personnel are connecting the wrong vessels to oxygen supply systems, despite connection incompatibilities. Patients continue to suffer injury or death.

III. RECOMMENDATIONS

All of the incidents described above could have been avoided if a few simple safety procedures had been followed. It is important that ***all*** employees handling a medical gas be alerted to and reminded of the possible hazards associated with using medical gas.

The Agency recommends implementing the following:

1. If your facility receives medical gas deliveries, you should store medical grade products separately from industrial grade products. The storage area for medical grade products should be well defined with one area for receiving full cryogenic vessels and another area for storing empty vessels.

2. All personnel who will be handling medical gases should be trained to recognize the various medical gas labels. Personnel should be trained to examine all labels carefully.

3. If your supplier uses 360-degree wrap-around labels to designate *medical oxygen*, personnel should be specifically trained to make sure each vessel they connect to the oxygen system bears such a label.

4. Make sure that all personnel in your facility who are responsible for changing or installing cryogenic vessels are trained to connect medical gas vessels properly. Personnel should understand how vessels are connected to the oxygen supply system and be alerted to the serious consequences of changing connections.

5. You should emphasize repeatedly that the fittings on these vessels should ***not be changed*** under any circumstances. If a cryogenic vessel fitting does not seem to connect to the oxygen supply system fitting, the supplier should be contacted immediately. The vessel should be returned to the supplier to determine the fitting or connection problem.

6. Once a cryogenic vessel is connected to the oxygen supply system, but ***prior*** to introducing the product into the system, a knowledgeable person should ensure that the correct vessel has been connected properly

We urge you to take every opportunity to promote the importance of properly handling medical gases. Alert all personnel in your facility, but especially those who are directly responsible for handling medical gas, to the potential hazards involved.

IV. REPORTING ADVERSE EVENTS OR ERRORS TO FDA

Medical gases are prescription drugs. Therefore, all medical gas manufacturers who receive reports of death or serious injury associated with the use of medical gases are required under 21 CFR 310.305 and/or 314.80 to report those incidents to the FDA.

Hospitals, nursing homes, and other health care facilities should submit reports to CDER (301-594-0095) or directly to FDA_s voluntary reporting program, MedWatch, by phone (800) FDA-1088, by facsimile (800) FDA-0178, or by mail to MedWatch, Food and Drug Administration (HFA-2), 5600 Fishers Lane, Rockville, Maryland, MD, 20857-9787.

[1] This guidance was developed by the Office of Compliance in the Center for Drug Evaluation and Research (CDER), Food and Drug Administration.

[2] Cryogenic vessels are used to contain material that is stored at very low temperatures.

Upcoming Changes to Enforcement Procedures

In order to promote cost effectiveness and to ensure the availability of funds to prosecute high-priority complaints, the Respiratory Care Board of California (Board) is moving forward with revisions to its Enforcement Program operating procedures. Included are revisions to its disciplinary guidelines, broadening its cite and fine program, and modifying the discipline sought for lower priority violations of the Respiratory Care Practice Act and its regulations through the in-house review.

The concepts of the proposed revisions were approved by the Board at its November, 2001 meeting. Currently, the Board's legal counsel and Deputy Attorney General Liaison are reviewing the proposal and determining the regulatory and legislative language needed to implement the revisions. The Board anticipates beginning the regulatory and legislative, if necessary, processes to establish these changes after its February 22, 2002 meeting, with a planned implementation date near January 1, 2003. The proposed changes are expected to have a significant impact in reducing enforcement expenditures for lower-priority cases.

Highlights of changes include:

Citation and Fine Program

The proposed revisions include the expansion of the Board's cite and fine program to include the authority to cite and fine licensed respiratory care practitioners (or applicants who have agreed to stipulate to the issuance of a citation and fine in exchange for an unconditional license) for any violation of the Respiratory Care Practice Act and its regulations.

'the Board can avoid accruing thousands of dollars in investigative, attorney and hearing costs, which in turn also reduces costs paid by applicants and licensees by way of cost recovery'

This mechanism is crucial in reducing enforcement expenditures associated with processing cases through investigations (if applicable), the Office of the Attorney General, and sometimes the Office of Administrative Hearings. Currently, cases where an applicant or licensee has a single DUI that occurred within three years are referred to the Office of the Attorney General for formal discipline. This entails the filing of a charging document (either an Accusation or a Statement of Issues) and generally results in a stipulated settlement placing the applicant or licensee on probation with terms and conditions that include biological fluid testing, cost recovery ($200 - $1,000), monthly probation costs, and other terms and conditions.

With the implementation of the expanded cite and fine program, a person with one DUI (or another qualifying violation) and no prior history will be fined anywhere from $100 to $500, depending upon any mitigating or aggravating circumstances. The issuance of citations and fines will be conducted through the Board office. Therefore, the Board can avoid accruing thousands of dollars in investigative, attorney and hearing costs, which in turn also reduces costs paid by applicants and licensees by way of cost recovery. And at the same time the Board can meet its legislative mandate to protect consumers by making this information available to the public and employers.

Disciplinary Guidelines Revisions

The proposed revisions include the addition of "mitigating" and "aggravating" circumstances to be considered by Administrative Law Judges in ordering discipline in their proposed decisions as follows:

Evidence in Aggravation of Penalty

1. Patient's trust, health, safety or well-being was jeopardized.
2. Patient's or employer's trust violated (i.e. theft, embezzlement, fraud, etc...).
3. Violations involved or were in the presence of children.
4. History of prior discipline.
5. Patterned behavior: respondent has a history of one or more violations or convictions related to the current violation(s).
6. Perjury on official Board forms.
7. Any other circumstances of an arrest or violation that resulted in a conviction or discipline.
8. Violent nature of crime or act.
9. Violation of Board Probation.
10. Failure to provide a specimen for testing in violation of terms and conditions of probation.

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...Enforcement Procedures continued form page 15

Evidence in Mitigation of Penalty

1. Recognition by Respondent of his or her wrongdoing and demonstration of corrective action to prevent recurrence.
2. Violation(s) or conviction(s) did not directly relate to any employment, health-related care, or an innocent bystander.
3. Respondent was forthcoming and reported violation or conviction to the Board.
4. A substantial amount of time since the violation or conviction (generally 4 or more years) occurred.
5. No prior criminal or disciplinary history.

In-House Review / Penalty Determination

The Board is proposing the following guidelines for Board staff when reviewing criminal history for applicants and licensees. The goal of the in-house review program is to reduce the costs of the Board's enforcement function by providing for proposed discipline with a minimal amount of investigation, attorney and judicial resources, while at the same time carrying out the mission of the Board.

The In-House Review is limited to the following categories which, based upon past experience, is a significant portion of the Board's enforcement caseload:

- FRAUD (which can include welfare and other government fraud and misrepresentation and conspiracy to commit fraud)
- THEFT (which can include petty theft, receiving stolen property and trespass)
- ALCOHOL (which can include DUI, reckless driving, public intoxication and other use in violation of law);
- DRUGS (which can include both use, possession and possession for sale);
- BODILY INJURY (which can include domestic violence, assault, battery and attempted battery).

To qualify for in-house review and determination of penalty, the following criteria would need to be met for the particular offense or applicant:

* Violations (with the exception of drug offense) must be misdemeanors;
* A child must not be the victim of the offense;
* The violation must not have occurred during the practice of respiratory care;
* Bodily injury resulting from the offense must not be to an unknowing victim, innocent bystander or defenseless person;
* Bodily injury resulting from the offense must not have been the result of premeditation;
* The offense must not have been extremely violent in nature, and must not have involved harassment or stalking;
* Felony drug or alcohol offenses may qualify for in-house review and determination of penalty provided no other disqualifying factor is present.

Only fraud, theft, alcohol, drugs, and bodily injury related offenses may qualify for in-house review and determination of penalty provided no other disqualifying factor is present

Cases not qualified for this review, will be reviewed individually and on a case-by-case basis for suggested discipline.

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Applicant Penalty Determination Guidelines

One violation older than two years from the date the application is received	Strong Warning Letter
Not more than one violation in any related category and all violations are older than three years from the date the application is received	Strong Warning Letter
No more than two violations in any category and not exceeding five from all categories and all are more than seven years old	Strong Warning Letter
Any violation(s) that does not meet the qualifications in numbers A1 –A3	Citation and Fine or Probation
Multiple violations that show patterned behavior and at least two violations or convictions showing that patterned behavior must have occurred within 3 years from the date that application for licensure is received	Denial
Perjury on any Respiratory Care Board form that conceals any violation or would in anyway benefit the applicant	Citation and Fine, Probation or Denial

Licensee Penalty Determination Guidelines

One violation - excluding drugs	Cite and Fine
Not more than one violation in any related category (within 10 years) and only one violation is less than five years old - excluding drugs	Cite and Fine
Any violation after licensure for drug use/possession	Probation (possible cite and fine)
Two or more violation(s) in any category (within 10 years)	Probation or Revocation (possible cite and fine)
Multiple violations (generally 3 or more) that show patterned behavior and at least two violations or convictions showing that patterned behavior must have occurred within the last five years	Revocation (minimal possibility of probation)
Perjury on any Respiratory Care Board form that conceals any violation or would in anyway benefit the licensee	Citation and Fine $1,000 for first offense, $2,500 thereafter plus any other appropriate discipline

The Board may also be seeking Legislative amendments to allow those practitioners placed on probation to petition the Board for early termination of probation or modification of terms and conditions of probation earlier.

If you are unable to attend the Board's meeting on February 22, 2002, please watch our Web site thereafter for more information on changes to come about with the Board's enforcement operating procedures. At its February 22nd meeting, the Board will also be discussing the need for an immediate remedy (prior to the fore-mentioned revisions to its enforcement procedures program take effect) to ensure discipline imposed for a single DUI is appropriate in ALL cases.

Respiratory Care Board of California * 444 North 3rd Street, Suite 270 * Sacramento CA * 95814
Web Site Address: www.rcb.ca.gov Telephone Number: (916) 323-9983

Disciplinary Actions Taken
From July 1, 2000 through June 30, 2001

FINAL DECISIONS
REVOKED OR SURRENDERED

ABRAMYAN, Karine, RCP 16089
Santa Monica, CA
ACOSTA, Fanny, RCP 1423
Glendora, CA
ADAMS, Gideon W. RCP 8351
Boulder Creek, CA
AMBERS, Martin W. RCP 4091
Vacaville, CA
ARMOR, Rosilyn C., RCP 8341
Compton, CA
AVERY, Michael A., RCP 6904
Palmdale, CA
BAILEY, Jeffrey D., RCP 18719
San Diego, CA
BALLENTINE, Robert, RCP 10934
Encinitas, CA
BARNSTEAD, SANDRA, RCP 5544
Huntington Beach, CA
BECKER, Jamie Rae, RCP 18014
San Lorenzo, CA
BLACK, Joe, RCP 9005
Inglewood, CA
BOOK, Donna J., RCP 4911
Newport Beach, CA
BOOTH, Jamie Lee, RCP 17011
Simi Valley, CA
BRESSICKELLO, John Anthony
RCP 19228
Torrance, CA
BUTLER, John J., RCP 11752
Stockton, CA 95209
CAMPBELL, Francis M., RCP 6764
San Jose, CA
CANTILADO, Steven, RCP 19202
San Pedro, CA
CARTER, Michael A., RCP 10886
Chatsworth, CA
CHRISTOFFERSON, Terry,
RCP 14077
Chico, CA
CONTRERAS, Kelly R., RCP 15339
Lodi, CA
COOKSON, Philip A., RCP 19321
San Diego, CA
CURRAN JR., John F., RCP 16030
Jamul, CA
DUNCAN, Laura, RCP 15186
Newhall, CA
FRANK, Renee, RCP 15281
Westminster, CA
GREGORY, Richard C.,RCP 11151
Anderson, CA
GYENES, Tibor George, RCP 12630
West Hollywood, CA
HAKEL, Ralph Walter, RCP 10413
Grizzly Flats, CA
HALLEX-RAMIREZ, Maria, RCP 13656
Lake Arrowhead, CA
HARRIS, Okera Kandie, RCP 20856
San Diego, CA
HERNANDEZ, Tony R., RCP 12611
Porterville, CA
HICKMAN, Dewayne, RCP 15502
Anaheim, CA
HOLLAND JR., Douglas T. RCP 1556
Rancho Cordova, CA
HOLMES JR., Robert Lee, RCP 19396
San Diego, CA
KASZAS, Susan, RCP 15056
Los Angeles, CA
KRIER, Alan Edward, RCP 13963
Los Angeles, CA
LAWAY, Sandro I., RCP 12958
Escondido, CA
LEVERATTO, Sandro, RCP 17974
Riverside, CA
MIGLIN, Robert A., RCP 130
Encino, CA
OROZCO JR., Fidel, RCP 13067
Pacoima, CA
PARKER, Elizabeth A., RCP 11921
Tucson, AZ
PATTON, Michael John, RCP 19457
El Cajon, CA
PEDERSEN, Craig A., RCP 7174
San Diego, CA
PRICE, Timothy Abell, RCP 11843
Palo Alto, CA
PRUITT, Michael David, RCP 16085
El Toro, CA
QUIROZ, Robert, RCP 16931
San Jose, CA
RODGERS, Patrick, RCP 16218
Long Beach, C A
RODRIGUEZ, David M., RCP 19926
Portola, CA
RODRIGUEZ, Ramon, RCP 11912
Canyon Country, CA
ROLEY, Justin Thomas, RCP 19485
Stockton, CA
ROMERO JR., Orlando, RCP 19163
Victorville, CA
SANTIAGO, Reynaldo R., RCP 432
Los Angeles, CA
SMITH, Ricky aka SABREE, Rick
RCP 14097
Mesquite, TX
STRAWN, Diane Lee, RCP 14344
La Mirada, CA
THOMAS, Billy R., RCP 5493
Los Angeles, CA
TRUMPLER, Stacie Ann, RCP 15509
San Pedro, CA
VAN ZITTER, Peter Emile, RCP 9195
Cerritos, CA
VOLPEZ, Pablo Enriquez, RCP 19402
Riverside, CA
WHITE, Sethyne, RCP 8246
Reno, Nevada
WILBUR, Frank Michael, RCP 17110
Victorville, CA
WILEY, Lisa Ann, RCP 15966
West Hollywood, CA
WILMOTH, Keith L., RCP 19745
Salinas, CA

STATEMENT OF ISSUES OR
ACCUSATIONS FILED

ATKINS, Marilyn Denise
AUSTIN, Pamela J., RCP 17565
BATTLE, Franklin J., RCP 7951
BENTON-POWLESS, K., RCP 17831
BOGHOSIAN, Joyce, RCP 1030
BOLIVAR, Raymundo, RCP 19262
BREAZEALLE, Wally, RCP 18938
BROOKS, Janice Yvonne, RCP 2218
CASE, Kathleen M., RCP 11190
CLARK, Raymond, RCP 17564
CLARK, Stephen John, RCP 15334
CURRIE, Deborah Lynn, RCP 18346
ELIZALDE, Christian, RCP 20330
GARDNER, Tatia H., RCP 19312
GONZALES, Stephanie, RCP 19296
GWILLIAM, Alfred Hans, RCP 17521
HILL, Jeffrey Lance
JANTZ, Dana Jeanette, RCP 11396
KAZARIAN, Garabed Garo
KIM, Karen I., RCP 13901.
KUSCH, Marick M., RCP 20718.
LOVE, Trina Sally, RCP 16215
LYLE, Terry Patrick, RCP 7042
MARTIN, Albert Allen, RCP 4132
MCCARTNEY, Ian A., RCP 18355
MCGUIRE, Thomas Mathew
MILLER, Larry R., RCP 7159
RYAN, Susan Marie, RCP 10533
SCHNUCH, Frederick H., RCP 19985
SENGENDO, Julius, RCP 18216
SPRAGUE, Thomas B., RCP 19099
STRAUSS, Thomas W., RCP 10794.
VALENZUELA, Ruel S., RCP 19666
VAN HULL, Barbara P., RCP 2832
VIPOND, Mark Robert, RCP 21352
WINN, Venius, RCP 17534

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...Disciplinary Actions continued from page 18

PLACED ON PROBATION / ISSUE CONDITIONAL LICENSE

ANDERSON, David A. RCP 9361
ANDERSON, Michael, RCP 17825
APSEY, Jr., Robert J. RCP 15343
ARMOUR, Benjamin J. RCP 17836
BALCHUNAS, Michael, RCP 3720
BARANCZYK, Terri, RCP 5607
BARROW, Sheila Y., RCP 20967
BATTLE-MONTOYA, Susan, RCP 16238
BRUHL, Jimmy F., RCP 2374
BUNCE, Polly C., RCP 13506
BURNS, Lois Elaine, RCP 19790
CAMPOS, Debra Jean, RCP 15344
CARSON, Deborah M.
COSA (SCHIRA), Simona, RCP 20610
CUDNEY, Cindy Marie
DAVILA, Fabricio Martin, RCP 17237
DEMOUCHET, Kerry D., RCP 617
DUBBS, L. Bryan, RCP 5913
EVANADO, Eddie Arbias, RCP 2846
FEATHER, David, RCP 20471
GAOS, Charles, RCP 8962
GALLAWAY, James D., RCP 4006
GIRON, Carlos Roberto, RCP 16136
GOWAN, Catherine A., RCP 217
HERRERA, Damien, RCP 20799
ILANO, Joel Garcia, RCP 15188
IRA, Lorenzo Gurney, RCP 20271
JACOB, Irene Elizabeth, RCP 222
JANOLINO, Rudivar, RCP 15688
JORDAN, Richard, RCP 2238
KELLY, Mario Alberto
KIM, Chang Soo, RCP 2920
KIMBALL, Julie Lynn, RCP 5832
KING, Daniel Lee, RCP 12286
LEO, Harold Reith, RCP 4770
MARTINEZ, Gabriel, RCP 12413
MENDEZ, Aracely
MERCURE, Timothy, RCP 2857
MERRIS, Kathleen S., RCP 5524
MINOR, Barbara, RCP 18224
MORRIS, Wanda Faye, RCP 15602
MURPHY, John R., RCP 16060
NELSON-BALL, Leslie, RCP 9860
NICHOLAS II, Rafael R., RCP 20078
OLIVA, Joanne, RCP 3086
ORTEGA. Ernie I., RCP 12416
OSHODI, Olabiso O., RCP 19162
PAGADUAN, Donald, RCP 16841
PALMER, Luckett M., RCP 6560
PAREDES, Miguel G., RCP 5946
PRUM, Po, RCP 17834
RAMIREZ, Mark Anthony, RCP 6976
RELEFORD, Steven W.
SAMSON, Alfredo Jun, RCP 17537
SPRAGUE, Richard A., RCP 19625
STRACKBINE, Brad I., RCP 15561
STRAUSS, Kenneth G., RCP 4328
TAYLOR, Kenneth E., RCP 6998
TOWNSEND, John L., RCP 7145
TULIAU, Christopher Daniel
VARNER, Andrew
VEGA, Ernie Anthony, RCP 21909
WARREN, Roland E., RCP 6648
WASSERSTEIN, Martin, RCP 7943
WHITE Katherine R., RCP 21905
WILLIAMS, Jason D., RCP 21900
WILLIAMS, Larry M., RCP 8700
WOOLEY II, Johnny R., RCP 14957

PUBLIC REPRIMAND

BLUE-SPARKS, Jacq. RCP 17711
DEVAPRIYAM, Paulraj, RCP 14180
HAGOS, Mulu Telele, RCP 17908
LIND, Edward Richard, RCP 9701
REINHEIMER, Lee I., RCP 14183
RICKETTS, Denise M., RCP 8342
SINGH, Gurnidar, RCP 18111
ZONA, Laura A., RCP 20336

ACCUSATION AND/OR PETITION TO REVOKE PROBATION FILED

BRODSKY, Ted Marc, RCP 1668
BROOMFIELD, Shirley, RCP 18637
CLACK, John Steven, RCP 19606
FOX, Don George, RCP 13807
HILL, Ronnetta Eugenia, RCP 9530
JOHNSON, April Joy, RCP 15932
MCKINNEY, Ronald Alan, RCP 17769
MONTGOMERY, James, RCP 16997
PARAGUYA, Rodines O., RCP 15103
POCKNETT, Dwayne A., RCP 19276
QUITASOL, Edgar, RCP 19317
RICE, Richard Eugene, RCP 9287
SPENCER, Karen, RCP 17805

OTHER DISCIPLINE

BAKER, Joanne L. RCP 1301
ESTELLE, Veronni Kaye, RCP 10840
GAUL, John Ashley
LLOYD, Loudii D.
MADRUGA, Rodney Mark
MASON, Gregory J.
PLATT, Bryan Richard

DEFINITIONS

Final Decisions
Decisions become operative on the effective date, except in situations where the court orders a stay. This may occur after the publication of this newsletter.

Accusations Filed
An Accusation is the legal document wherein the charge(s) and allegation(s) against a licensee are formally pleaded.

Statements of Issues Filed
When an applicant for licensure is informed that the license will be denied for cause, the applicant has a right to demand a formal hearing, usually before an Administrative Law Judge (ALJ). This process is initiated by the filing of a Statement of Issues (SOI), which is similar to an Accusation, wherein the cause for denial is formerly pleaded.

Accusation and/or Petition to Revoke Probation
An Accusation and/or Petition to Revoke Probation is filed when a licensee is charged with violating the terms or conditions of his or her probation and/or with additional violations of the Respiratory Care Practice Act.

For more information regarding disciplinary action taken against any of the individuals listed, please contact Denise Robertson, Enforcement Coordinator. For information regarding individuals on probation, contact Colleen Long in the Probation Unit. The above RCB staff can be reached at (916) 323-9983.

To order copies of the legal pleadings, please send a written request, including the name and license number (if applicable) of the respondent, to:

Attention: Andrea Pina-Gloria
Respiratory Care Board
444 North 3rd Street, Ste. 270
Sacramento, CA 95814

PLACE AN AD!

The *Respiratory Update* newsletter features current information on the business of the Respiratory Care Board of California (Board) and other matters affecting the profession. It is currently published two times each year, and in the future may be published up to four times per year.

The *Respiratory Update* is a two-color newsletter distributed to over 16,000 active respiratory care practitioners licensed in the State of California and to as many as 600 applicants for licensure. Each newsletter is generally 6 to 14 pages in length.

The Board is considering offering space in its newsletter for advertising. If you would like more information on placing an ad in one or more issues of the Respiratory Update, please contact Jennifer Mercado at (916) 323-9983 or send her an e-mail at: rcbinfo@dca.ca.gov and request a proposed advertisement package.

HAVE YOU MOVED?

Remember, you must notify the Board in writing if you have changed your address of record within 14 days of such change. Your written request must include your RCP number, your previous address, your new address, and your signature. The Board office will accept faxed notification. However address changes are not taken over the telephone for security reasons.

Respiratory Care Board of California
444 North 3rd Street, Suite 270
Sacramento, CA 95814